



INSURANCE INFORMATION

CHILD'S NAME _____ DATE _____
(LAST) (FIRST) (MI)

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

HOME PH# _____ SEX _____ DATE OF BIRTH _____ SS# _____

PRIMARY CARE PHYSICIAN _____ PHYSICIAN PHONE# _____

INSURED'S NAME _____ SS# _____ HOME PH# _____

DATE OF BIRTH _____ EMPLOYER _____ CELL PH# _____

SPOUSE NAME _____ HOME PH# (if different) _____ CELL PH# _____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY _____ PHONE# _____

BILL ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURED'S NAME _____ ID# _____

GROUP # _____ HMO _____ PPO _____ PAYOR ID # _____

DEDUCTIBLE AMOUNT _____ AMOUNT MET _____ TYPE POLICY _____ CO PAY AMOUNT _____
(100%, 80/20, ETC.)

MAX VISITS _____ VISITS MET _____ POLICY PERIOD _____ AUTHORIZATION NEEDED _____

EXCLUSIONS/LIMITATIONS _____

INSURANCE REP'S NAME _____ CONFIRMATION # _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY _____ PHONE# _____

BILL ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURED'S NAME _____ ID# _____

GROUP # _____ HMO _____ PPO _____ PAYOR ID # _____

DEDUCTIBLE AMOUNT _____ AMOUNT MET _____ TYPE POLICY _____ CO PAY AMOUNT _____
(100%, 80/20, ETC.)

MAX VISITS _____ VISITS MET _____ POLICY PERIOD _____ AUTHORIZATION NEEDED _____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BACKYARD TREEHOUSE PEDIATRIC THERAPY CENTER, P.C.

SIGNATURE OF PARENT/LEGAL GUARDIAN

DATE